CMS Manual System

Pub. 100-02 Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 18 **Date: SEPTEMBER 3, 2004**

CHANGE REQUEST 3449

NOTE: Transmittal 12, CR 3063, dated May 28, 2004, is being rescinded and replaced with CR 3449.

SUBJECT: Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy. Full Replacement of CR 3063

I. SUMMARY OF CHANGES: Manualizes definitions of Chiropractic maintenance therapy and the reason for denials. Adds a requirement that the AT modifier be used in all cases where active/corrective treatment is being performed. Explains that chiropractic claims billed without this modifier are considered maintenance therapy and will be denied. Deletes the paragraph in chapter 15, section 240.1.5 about carrier development of parameters for an extension in course of treatment. Revises language in CR 3063 to further explain that contractors that have Local Coverage Determinations (LCDs) with frequency limits shall instruct chiropractors that they may submit claims for services that exceed the frequency limits established within the LCD with or without the AT modifier depending on whether the chiropractor believes they have rendered active treatment or maintenance therapy, respectively, and that GA or GZ modifiers may be appropriate. Claims with or without an AT modifier will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD. If contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, contractors may deny if appropriate after medical review.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: October 4, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/30.5/Chiropractor's Services
R	15/240.1.3/Necessity for Treatment
R	15/240.1.5/Treatment Parameters

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 18	Date: September 3, 2004	Change Request 3449

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SUBJECT: Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy. Full Replacement of CR 3063

I. GENERAL INFORMATION

A. Background: Chapter 15, section 30.5 of Pub. 100-02, Benefits Policy Manual states that chiropractic maintenance therapy is not medically reasonable or necessary and is not payable under the Medicare program.

The 2003 Improper Medicare FFS Payments report indicates that chiropractors have the highest Provider Compliance Error Rate in Medicare. The report indicates that chiropractors filed claims incorrectly almost a third of the time. In order to help chiropractors bill Medicare correctly, they need a way to indicate on each claim they submit, which claims are for active/corrective therapy and which are for maintenance therapy. A modifier ("AT") already exists for acute treatment.

B. Policy: For Medicare purposes, the AT modifier shall now be used only when chiropractors bill for active/corrective treatment. This CR requires:

1) Every chiropractic claim (those containing HCPCS code 98940, 98941, 98942) with a date of service on or after October 1, 2004, to include the Acute Treatment (AT) modifier if active/corrective treatment is being performed; or

2) No modifier if maintenance therapy is being performed. Contractors shall deny a chiropractic claim (containing HCPCS code 98940, 98941, 98942) with a date of service on or after October 1, 2004, that does not contain the AT modifier.

Every claim for chiropractic active/corrective treatment with or without the AT modifier (depending on whether the chiropractor believes they have rendered active treatment or maintenance therapy, respectively) will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD. If contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, contractors may deny if appropriate after medical review. For those services that exceed the frequency limits established within the LCD, chiropractors may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA or GZ modifier as appropriate.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Carriers and Program Safeguard Contractors (PSCs) who do medical review shall post this article, or a direct link to this article,

on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. In addition, contractors are encouraged, within available resources, to educate Chiropractors through seminars, conferences, etc. as they deem appropriate.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3449.1	Effective for dates of service October 1, 2004 and later, carriers shall deny any chiropractic claim that lacks an AT modifier.			X						
3449.2	Effective for dates of service October 1, 2004 and later, carriers shall autodeny claims with an AT modifier, by instituting a frequency edit if the claims exceed the frequency limits of reasonable and necessary services specified in an LCD.			X						
3449.3	Effective immediately, each contractor shall educate chiropractors in their jurisdiction that beginning October 1, 2004, every claim for chiropractic active/corrective treatment must have the AT modifier and claims for maintenance therapy must be billed without the AT modifier.			X						PSCs doing medical review

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3449.4	Effective immediately, each contractor shall educate chiropractors in their jurisdiction that beginning October 1, 2004, every claim for chiropractic active/corrective treatment with or without the AT modifier (depending on whether the chiropractor believes they have rendered active treatment or maintenance therapy, respectively) will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in an LCD. If contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, contractors may deny if appropriate after medical review. Also, for those services that exceed the frequency limits established within the LCD, chiropractors may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA or GZ modifier as appropriate.			X						PSCs doing medical review

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2004 **Implementation Date: October 4, 2004** **Pre-Implementation Contact(s):** For medical review issues contact Dan Schwartz (dschwartz2@cms.hhs.gov), for CERT issues, Melanie Combs (mcombs@cms.hhs.gov, for policy issues, Terri Harris (tharris1@cms.hhs.gov). **Post-Implementation Contact(s):** Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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30.5 - Chiropractor's Services

(Rev. 18, Issued 09-03-04, Effective: 10-01-04, Implementation: 10-04-04)

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet the following uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

If a chiropractor orders, takes, or interprets an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the x-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor. For detailed information on using x-rays to determine subluxation, see §240.1.2.

In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.

A - Uniform Minimum Standards

Prior to July 1, 1974

Chiropractors licensed or authorized to practice prior to July 1, 1974, and those individuals who commenced their studies in a chiropractic college before that date must meet all of the following three minimum standards to render payable services under the program:

- Preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

- Graduation from a college of chiropractic approved by the State's chiropractic examiners that included the completion of a course of study covering a period of not less than 3 school years of 6 months each year in actual continuous attendance covering adequate course of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing, and adjusting; and

- Passage of an examination prescribed by the State's chiropractic examiners covering the subjects listed above.

After June 30, 1974

Individuals commencing their studies in a chiropractic college after June 30, 1974, must meet all of the above three standards and all of the following additional requirements:

- Satisfactory completion of 2 years of pre-chiropractic study at the college level;

- Satisfactory completion of a 4-year course of 8 months each year (instead of a 3-year course of 6 months each year) at a college or school of chiropractic that includes not less than 4,000 hours in the scientific and chiropractic courses specified in the second bullet under "**Prior to July 1, 1974**" above, plus courses in the use and effect of x-ray and chiropractic analysis; and

- The practitioner must be over 21 years of age.

B - Maintenance Therapy

Under the Medicare program, chiropractic maintenance therapy is not *considered to be medically reasonable or necessary, and is therefore not payable.* Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. *When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.*

240.1.3 - Necessity for Treatment

(Rev. 18, Issued 09-03-04, Effective: 10-01-04, Implementation: 10-04-04)

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.

Most spinal joint problems fall into the following categories:

- Acute subluxation-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, *or arrest of progression,* of the patient's condition.

- Chronic subluxation-A patient's condition is considered chronic when it is not expected to *significantly improve or be resolved with further treatment* (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, *without expectation of additional objective clinical improvements,* further manipulative treatment is considered maintenance therapy and is not covered.

*For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. Carriers may develop local coverage determinations (LCDs) that indicate an appropriate frequency of service for a given clinical indication. Contractors that have LCDs with frequency limits that define the limits of reasonable and necessary care shall instruct chiropractors that they may submit claims for services that exceed the frequency limits established within the LCD with or without the AT modifier depending on whether the chiropractor believes they have rendered active treatment or maintenance therapy, respectively. Claims with an AT modifier will continue to be autodenied if the services exceed the frequency limits of reasonable and necessary services specified in the LCD. If contractors' LCDs do not specify frequencies that define the limit of reasonable and necessary care, contractors may deny if appropriate after medical review.*

For those services that exceed the frequency limits established within the LCD chiropractors may wish to obtain an Advance Beneficiary Notice (ABN) from the beneficiary and also apply the GA or GZ modifier as appropriate.

A - Maintenance Therapy

Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, *or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.*

B – Contraindications

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart. The following are **relative contraindications** to dynamic thrust:

- Articular hypermobility and circumstances where the stability of the joint is uncertain;
- Severe demineralization of bone;
- Benign bone tumors (spine);
- Bleeding disorders and anticoagulant therapy; and
- Radiculopathy with progressive neurological signs.

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis;
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
- A significant major artery aneurysm near the proposed manipulation.

240.1.5 - Treatment Parameters

(Rev. 18, Issued 09-03-04, Effective: 10-01-04, Implementation: 10-04-04)

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as 3 months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.